THIS FORM TO BE COMPLETED BY EXAMINING PHYSICIAN

Patient's Name: _____ Date of Birth: ______________ Reference #: _____

Vaccines	Dates of Basic Immunization	Booster
DPT-DT-Tetanus		
MMR		
Polio		
Hepatitis A		
Hepatitis B		
HIB		
Varicella		

I have examined the above named applicant on: _____

Note that the examination must have been within the last year.

- Patient's Blood Pressure: _____ Heart Rate: _____
- Height: _____ Weight: _____
- Patient has the following allergies : _____
- Medication and/or treatment to be continued at camp:_____

_____

- In my professional opinion his/her condition does____/ does not ____ preclude participation in an active camp program.
- Patient was found to be in good health with the following exceptions: _____

_____

Doctor- Sign Here!

Physician's Signature:_____Date:_____

No stamps will be accepted.

Physician's Name:_____ Telephone #: _____

The following medications, or others in their class, are acceptable for administration as per dosages as labeled except as noted below:

Name of medication	*Exception*
Acetaminophen (Tylenol)	
Antibiotic Ointment	
Anti-Diarrheal	
Anti-Fungal Cream	
Benadryl	
Claritin	
Cortisone Ointment	
Cough Syrup—DM	
Dramamine	
Gas-X	
Ibuprofen (Advil)	
Milk of Magnesia	
Senna-Lax	
Sudafed	
Tums	
Tylenol Cold	
Tylenol Sinus	
Vasocon—A	
Visine	
Other:	
Other:	
Other:	
Other:	

IMPORTANT
Please make sure that there is an adequate supply of any medication that your child is taking for the duration of his/her stay in camp.

At the suggestion of our doctors, allergy medication/shots should be started about a month prior to camp to facilitate relief during the summer. We will be glad to continue the treatments.